Available online at www.sciencedirect.com
ScienceDirect
journal homepage: http://www.elsevier.com/locate/crvasa

Guidelines

2017 ESC focused update on dual antiplatelet therapy in coronary artery disease developed in collaboration with EACTS☆

Zuzana Moťovská [a,*], *Ivo Varvařovský* [b], *Petr Ošťádal* [c]

[a] *III. interní-kardiologická klinika, 3. LF UK a FNKV, Praha, Czech Republic*
[b] *Kardiocentrum, Nemocnice na Homolce, Praha,, Czech Republic*
[c] *Kardiologické centrum Agel, Pardubice, Czech Republic*

Authors of the original ESC/EACTS full text document [1]: Marco Valgimigli, Héctor Bueno on behalf of the The Task Force for dual antiplatelet therapy in coronary artery disease of the European Society of Cardiology (ESC) and of the European Association for Cardio-Thoracic Surgery (EACTS).

ARTICLE INFO

Article history:
Received 13 October 2017
Accepted 14 October 2017
Available online xxx

EUROPEAN SOCIETY OF CARDIOLOGY®

ČESKÁ KARDIOLOGICKÁ SPOLEČNOST
THE CZECH SOCIETY OF CARDIOLOGY

Contents

☆ For permissions: please e-mail: guidelines@escardio.org.

* *Corresponding author.*
E-mail address: motovska.zuzana@gmail.com (Z. Moťovská).

https://doi.org/10.1016/j.crvasa.2017.10.007

Please cite this article in press as: Z. Moťovská et al., 2017 ESC focused update on dual antiplatelet therapy in coronary artery disease developed in collaboration with EACTS, Cor et Vasa (2017), https://doi.org/10.1016/j.crvasa.2017.10.007

1. Preamble

Guidelines and Focused Updates written under the auspices of the European Society of Cardiology's (ESC) Committee for Practice Guidelines (CPG) summarize and evaluate available evidence with the aim of assisting health professionals in selecting the best management strategies for an individual patient with a given condition (Tables 1 and 2).

2. Introduction

After 21 years of research, dual antiplatelet therapy (DAPT) has moved from a local (i.e. stent-related) to a systemic treatment strategy (i.e. capable of preventing thrombotic arterial vessel occlusion), conveying global patient protection (Fig. 1).

3. Efficacy and safety of dual antiplatelet therapy and risk stratification tools

3.1. *Risk stratification tools for ischaemia and bleeding risks*

Given the trade-off between ischaemic vs. bleeding risks for any given DAPT duration, the use of scores might prove useful to tailor DAPT duration in order to maximize ischaemic protection and minimize bleeding risks in the individual patient. The use of risk scores that were specifically designed to guide and inform decision making on DAPT duration should be prioritized over other available risk scores (Table 3).

Use of risk scores as guidance for the duration of dual antiplatelet therapy.

Recommendation	Class[a]	Level[b]
The use of risk scores designed to evaluate the benefits and risks of different DAPT durations[c] may be considered.	IIb	A

DAPT = dual antiplatelet therapy.
[a] Class of recommendation.
[b] Level of evidence.
[c] The DAPT and PRECISE-DAPT scores are those currently fulfilling these requirements.

3.2. *Type of $P2Y_{12}$ inhibitor and timing of initiation*

Recommendations on $P2Y_{12}$ inhibitor selection and timing.

Recommendations	Class[a]	Level[b]
In patients with ACS, ticagrelor (180 mg loading dose, 90 mg twice daily) on top of aspirin[c] is recommended, regardless of initial treatment strategy, including patients pre-treated with clopidogrel (which should be discontinued when ticagrelor is commenced) unless there are contraindications.	I	B
In patients with ACS undergoing PCI, prasugrel (60 mg loading dose, 10 mg daily dose) on top of aspirin is recommended for $P2Y_{12}$ inhibitor-naïve patients with NSTE-ACS or initially conservatively managed STEMI if indication for PCI is established, or in STEMI patients undergoing immediate coronary catheterization[c] unless there is a high risk of life-threatening bleeding or other contraindications.	I	B
Pre-treatment with a $P2Y_{12}$ inhibitor is generally recommended in patients in whom coronary anatomy is known and the decision to proceed to PCI is made as well as in patients with STEMI.	I	A
In patients with NSTE-ACS undergoing invasive management, ticagrelor administration (180 mg loading dose, 90 mg twice daily), or clopidogrel (600 mg loading dose, 75 mg daily dose) if ticagrelor is not an option, should be considered as soon as the diagnosis is established.	IIa	C
In patients with stable CAD, pre-treatment with clopidogrel may be considered if the probability of PCI is high.	IIb	C
Clopidogrel (600 mg loading dose, 75 mg daily dose) on top of aspirin is recommended in stable CAD patients undergoing coronary stent implantation and in ACS patients who cannot receive ticagrelor or prasugrel, including those with prior intracranial bleeding or indication for OAC.	I	A

Please cite this article in press as: Z. Moťovská et al., 2017 ESC focused update on dual antiplatelet therapy in coronary artery disease developed in collaboration with EACTS, Cor et Vasa (2017), https://doi.org/10.1016/j.crvasa.2017.10.007